FOR BHF USE

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2005 STATE OF ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2005)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility Facility Name		-		II. CERTI	FICATION BY AUTHORIZED FACILITY OFFICER
Address:	800 North Market Street Number Knox	Knoxville City Fax # (309)289-8255	61448 Zip Code	State o and cer are true applica is base	re examined the contents of the accompanying report to the fillinois, for the period from 12/01/04 to 11/30/05 tify to the best of my knowledge and belief that the said contents e, accurate and complete statements in accordance with ble instructions. Declaration of preparer (other than provider) d on all information of which preparer has any knowledge.
Type of Own	l License for Current Owners:	PROPRIETARY Individual Partnership	GOVERNMENTAL State X County		(Signed) (Date) (Title) (Signed)
In the event t	on Code here are further questions about t	Corporation "Sub-S" Corp. Limited Liability Co. Trust Other this report, please contact:	Other	Paid Preparer	(Print Name and Title) (Firm Name Frost, Ruttenberg & Rothblatt, P.C. & Address) (Telephone) (B47) 236-1111 Fax ‡ (847) 236-1155 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 (Date) (Date) (Date)

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS Page 2

Faci	lity Name & ID Numl	ber Knox County	y Nursing Home				# 0010561 Report Period Beginning: 12/01/04 Ending: 11/30/05				
	III. STATISTICA	AL DATA					D. How many bed-hold days during this year were paid by the Department?				
	A. Licensure/	certification level(s) o	f care; enter numbei	r of beds/bed days,			None (Do not include bed-hold days in Section B.)				
	(must agree	with license). Date of	change in licensed b	oeds	N/A						
			J	_			E. List all services provided by your facility for non-patients.				
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)				
							None				
	Beds at				Licensed						
	Beginning of	Licensu	ıre	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census? Yes				
	Report Period	Level of		Report Period	Report Period		11.2005 the facility maintain a daily manight central.				
	report i criou	Level of	curc	Report I criou	Report 1 criou		G. Do pages 3 & 4 include expenses for services or				
1	204	Skilled (SN)	F)	204	74,460	1	investments not directly related to patient care?				
2	204		iatric (SNF/PED)	204	74,400	2	YES X NO				
3		Intermediat				3	120 110				
4		Intermediat	· · · · · · · · · · · · · · · · · · ·			4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?				
5						5	YES X NO				
6		Sheltered Care (SC) ICF/DD 16 or Less				6					
							I. On what date did you start providing long term care at this location?				
7	204	TOTALS		204	74,460	7	Date started 08/28/1966				
							J. Was the facility purchased or leased after January 1, 1978?				
	B. Census-For	r the entire report per	riod.				YES Date NO X				
	1	2	3	4	5						
	Level of Care	Patient Days	by Level of Care and	d Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?				
		Medicaid					YES X NO If YES, enter number				
		Recipient	Private Pay	Other	Total		of beds certified 26 and days of care provided 2,908				
	SNF	8,719	3,666	3,294	15,679	8					
	SNF/PED					9	Medicare Intermediary AdminaStar Federal				
	ICF	25,380	8,703	2,860	36,943	10					
	ICF/DD					11	IV. ACCOUNTING BASIS				
	SC					12	MODIFIED				
13	DD 16 OR LESS					13	ACCRUAL X CASH* CASH*				
14	TOTALS	34,099	12,369	6,154	52,622	14	Is your fiscal year identical to your tax year? YES X NO				
	C Parcent Oc	ccupancy. (Column 5,	line 14 divided by to	atal licancad			Tax Year: 111/30/05 Fiscal Year: 11/30/05				
		n line 7, column 4.)	70.67%	nai Heenseu			* All facilities other than governmental must report on the accrual basis.				
	zea aujo o.		/ 0	-	SEE ACCOUNTAN	NTS' CO	S' COMPILATION REPORT				

STATE OF ILLINOIS
__#__0010561 Page 3 11/30/05 **Facility Name & ID Number Knox County Nursing Home Report Period Beginning:** 12/01/04 **Ending:**

	V. COST CENTER EXPENSES (through	hout the report,	please round to	the nearest do	llar)						-	
	O 4: F		Costs Per Genera	-	70.4.1	Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification -	Total	ments	Total		40	
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	331,466	36,098	8,627	376,191		376,191		376,191			1
2	Food Purchase	100.001	311,303		311,303		311,303		311,303			2
3	Housekeeping	199,894	39,929		239,823		239,823		239,823			3
4	Laundry	66,120	23,572	103,715	193,407		193,407		193,407			4
5	Heat and Other Utilities			253,200	253,200		253,200	(2,590)	250,610			5
6	Maintenance	125,415	11,730	96,580	233,725		233,725		233,725			6
7	Other (specify):*											7
8	TOTAL General Services	722,895	422,632	462,122	1,607,649		1,607,649	(2,590)	1,605,059			8
	B. Health Care and Programs											
	Medical Director			9,500	9,500		9,500		9,500			9
	Nursing and Medical Records	2,739,241	166,576	7,898	2,913,715		2,913,715		2,913,715			10
10a	Therapy			5,077	5,077		5,077		5,077			10a
11	Activities	76,717		1,863	78,580		78,580		78,580			11
12	Social Services	105,051	6,625	1,863	113,539		113,539		113,539			12
13	CNA Training											13
	Program Transportation	19,758			19,758		19,758		19,758			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,940,767	173,201	26,201	3,140,169		3,140,169		3,140,169			16
	C. General Administration											
17	Administrative	73,237		4,800	78,037		78,037		78,037			17
18	Directors Fees											18
19	Professional Services			26,268	26,268		26,268		26,268			19
20	Dues, Fees, Subscriptions & Promotions			14,480	14,480		14,480		14,480			20
21	Clerical & General Office Expenses	146,679	20,091	268,757	435,527		435,527	(227,687)	207,840			21
22	Employee Benefits & Payroll Taxes			614,482	614,482		614,482	595,040	1,209,522			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,118	10,118		10,118	(1,929)	8,189			24
25	Other Admin. Staff Transportation			13,136	13,136		13,136	(530)	12,606			25
26	Insurance-Prop.Liab.Malpractice			13,691	13,691		13,691		13,691			26
	Other (specify):*											27
28	TOTAL General Administration	219,916	20,091	965,732	1,205,739		1,205,739	364,894	1,570,633			28
20	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,883,578	615,924	1,454,055	5,953,557		5,953,557	362,304	6,315,861			29
2)	(SUM OF TINES 8, 10 & 28) *Attach a schedule if more than one type						SEE ACCOUNT			Т		27

SEE ACCOUNTANTS' COMPILATION REPORT

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILA' NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Knox County Nursing Home

#0010561

Report Period Beginning:

12/01/04 Ending:

Page 4 11/30/05

V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			193,337	193,337		193,337	7,640	200,977			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,105	2,105		2,105	(2,105)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,520	2,520		2,520		2,520			35
36	Other (specify):*											36
37	TOTAL Ownership			197,962	197,962		197,962	5,535	203,497			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		289,838		289,838		289,838		289,838			39
40	Barber and Beauty Shops	19,902		1,062	20,964		20,964	(675)	20,289			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,690	111,690		111,690		111,690			42
43	Other (specify):*			1,215	1,215		1,215	(1,193)	22			43
44	TOTAL Special Cost Centers	19,902	289,838	113,967	423,707		423,707	(1,868)	421,839			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,903,480	905,762	1,765,984	6,575,226		6,575,226	365,971	6,941,197			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

0010561

Page 5

Ending: 11/30/05

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below. reference the line on which the particular cost was included. (See instructions.)

	In column	1 2 below,	reierence ine i	ine on wi	hich the particul	ar cos
			1	Refer-	OHF USE	
	NON-ALLOWABLE EXPENSES		Amount	ence	ONLY	
1	Day Care	\$			\$	1
2	Other Care for Outpatients					2
3	Governmental Sponsored Special Programs					3
4	Non-Patient Meals					4
5	Telephone, TV & Radio in Resident Rooms		(2,590)	05		5
6	Rented Facility Space					6
7	Sale of Supplies to Non-Patients					7
8	Laundry for Non-Patients					8
9	Non-Straightline Depreciation		7,640	30		9
10	Interest and Other Investment Income		(2,105)	32		10
11	Discounts, Allowances, Rebates & Refunds					11
12	Non-Working Officer's or Owner's Salary					12
13	Sales Tax			02		13
14	Non-Care Related Interest					14
15	Non-Care Related Owner's Transactions					15
16	Personal Expenses (Including Transportation)					16
17	Non-Care Related Fees					17
18	Fines and Penalties					18
19	Entertainment					19
20	Contributions					20
21	Owner or Key-Man Insurance					21
22	Special Legal Fees & Legal Retainers					22
23	Malpractice Insurance for Individuals					23
24	Bad Debt		(241,785)	21		24
25	Fund Raising, Advertising and Promotional					25
	Income Taxes and Illinois Personal					
26	Property Replacement Tax					26
27	CNA Training for Non-Employees					27
	Yellow Page Advertising		(17.00.2			28
29	Other-Attach Schedule		(16,084)		ļ.	29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	(254,924)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

12/01/04

2

		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$	31	1
32	Donated Goods-Attach Schedule*		32	2
	Amortization of Organization &			
33	Pre-Operating Expense		33	3
	Adjustments for Related Organization			
34	Costs (Schedule VII)	620,895	34	4
	Other- Attach Schedule		35	5
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 620,895	30	6
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 365,971	37	7

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.) 2

Yes No Reference Amount 38 Medically Necessary Transport. 38 39 40 Gift and Coffee Shops 40 41 Barber and Beauty Shops 41 42 Laboratory and Radiology 43 43 Prescription Drugs 44 Exceptional Care Program 44 45 Other-Attach Schedule 45 46 Other-Attach Schedule 47 TOTAL (C): (sum of lines 38-46)

	OHF USE ONLY					
48	4	49	50	51	52	

1 2 3 4 5	NON-ALLOWABLE EXPENSES		Amount	Reference	_
4	Farm Income	s	(1,193)	43	
4	Farm Income Beauty Shop Income Bank Charges		(1,193) (675)	43 40	
4	Bank Charges		(9)	21	
	Marketing Services		(11,748)	21	Ť
	Out of State Travel		(530)	25	*
6	Out of State Seminar		(1,929)	24	П
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82 83 84 85 86 87 88 89 90 91 92 93 94 95 96					2

STATE OF ILLINOIS

Summary A Facility Name & ID Number Knox County Nursing Home SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I # 0010561 Report Period Beginning: 12/01/04 **Ending:** 11/30/05

	SUMMARY OF PAGES 5, 5A, 6, 64	1, 0D, 0C, 0D,	01, 01, 03, 01	IMILDUI	1		1		I	l .		I	SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col	 7)
1	Dietary	3 & 3A	U	UA	UD UD	00	UD UD	OE.	OF	00	UII	01	(to Sch v, con	1
2	Food Purchase												+	2
3	Housekeeping												+	3
4	Laundry												+	4
5	Heat and Other Utilities	(2,590)											(2,590)	5
6	Maintenance	` / /												6
7	Other (specify):*												1	7
8	TOTAL General Services	(2,590)											(2,590)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services													19
20	Fees, Subscriptions & Promotions													20
21	Clerical & General Office Expenses	(253,542)	25,855										. , .	
22	Employee Benefits & Payroll Taxes		595,040										595,040	22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,929)											(1,929)	
25	Other Admin. Staff Transportation	(530)											(530)	
26	Insurance-Prop.Liab.Malpractice								ļ					26
-	Other (specify):*												<u> </u>	27
28	TOTAL General Administration	(256,001)	620,895										364,894	28
	TOTAL Operating Expense													1
29	(sum of lines 8,16 & 28)	(258,591)	620,895										362,304	29

STATE OF ILLINOIS

Knox County Nursing Home

0010561 Report Period Beginning: 12/01/04 Ending: 11/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Facility Name & ID Number

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6 A	6B	6C	6D	6E	6F	6 G	6H	6I	(to Sch V, col	.7)
30	Depreciation	7,640											7,640	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,105)											(2,105)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	5,535											5,535	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(675)											(675)	40
41														41
42	Provider Participation Fee													42
43	Other (specify):*	(1,193)											(1,193)	43
44	TOTAL Special Cost Centers	(1,868)											(1,868)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(254,924)	620,895										365,971	45

11/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1			2	3					
OWNER	RS		OTHER RELATED BUSINESS ENTITIES						
Name	Ownership %	Name		City		Name	City		Type of Business
Knox County	100%								
				2000			2.0.0		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sc	hedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
					_	Ownership	Organization	Costs (7 minus 4)	
1	V	22	Employee Benefits - IMRF	\$	Knox County	100.00%	\$ 282,159	\$ 282,159	1
2	V	22	Employee Benefits - FICA		Knox County	100.00%	312,881	312,881	2
3	V	21	Bookkeeping & Accounting		Knox County	100.00%	25,855	25,855	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 620,895	\$ * 620,895	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS]	Page 6A
#	0010561	Report Period Beginning:	12/01/04	Ending:	11/30/05

|--|

Nursing Home

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, YES NO management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Scho	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	i
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26 27
27	V								
28	V								28
29	V								29 30
30	V								
31	V		<u> </u>		<u> </u>				31 32
33	V								33
34	V								34
35	V	1							35
36	V	1							36
37	V			†		†			37
38	V					<u> </u>			38
	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS	5			I	Page 6B
#	0010561	Report Period Reginning	12/01/04	Ending	11/30/05

Facility Name & II) Number	Knox (County	Nursing

Knox (County	Nursing l	Home

VII. RE	LATED	PARTIES	(continued))
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В.	Are any costs included in this report which are a result of transactions with		
	management fees, purchase of supplies, and so forth.	YES	NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	i
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		•	\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
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25	V								25
26	V								26
27	V								27
28	V								28
29	V		<u></u>						29
30	V		<u></u>						30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V					<u> </u>			38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS					I	Page 6C	
	#	0010561	Report Period Reginning	12/01/04	Ending:	11/30/05	

acinty Name & 1D Number	Knox County Nursing H

VII. RELATED PARTIES (continued)		

3.	Are any costs included in this report which are a result of transactions with	ı rela	ted organizati	ons?]	This includes rent,
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		o whersing	\$	\$	15
16	V			*			T	•	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE (OF ILLINOIS	}			I	Page 6D	
	#	0010561	Report Period Reginning	12/01/04	Ending.	11/30/05	

						0
Facility Name & ID Number	Knox County Nursing Home	# 0010561	Report Period Beginning:	12/01/04	Ending:	11/30/05

VII. RELATED PARTIES (continued)

B.	Are any costs included in this report which are a result of transactions with	ı rela	ted organizati	ons? I	This includes rent,
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sched	lule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		o whereas	\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Γotal			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS	3				Page 6E			
#	0010561	Report Period Beginning:	12/01/04	Ending:	11/30/05			

VII. RELATED PARTIES (continued)	

Facility Name & ID Number

B.	Are any costs included in this report which are a result of transactions with	h relat	ted organizatio	ons? T	This includes rent,
	management fees, purchase of supplies, and so forth.		YES		NO

Knox County Nursing Home

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		o whersing	\$	\$	15
16	V			*			-	•	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS				I	Page 6F	
#	0010561	Report Period Beginning:	12/01/04	Ending:	11/30/05	

VII RE	CLATED	PARTIF	'S (continued)	

Facility Name & ID Number

V 11.	SKELATED TAKTIES (Continucu)									
B.	Are any costs included in this report which are a result of transactions with related organizations? This includes rent,									
	management fees, purchase of supplies, and so forth. YES NO									
	If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with									

the instructions for determining costs as specified for this form.

Knox County Nursing Home

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization		7	8 Difference:	
						Operating Cost	Adjustments for	
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
				9		Organization	Costs (7 minus 4)	
15 V			\$		Ownership	\$	\$	15
16 V								16
17 V								17
18 V								18
19 V								19
20 V								20
21 V								21
22 V								22
23 V								23
24 V								24
25 V								25
26 V								26
27 V								27
28 V								28
29 V								29
30 V								30
31 V								31
32 V								32
33 V								33
34 V								34
35 V								35
36 V								36
37 V								37
38 V								38
39 Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS	;			F	Page 6G
#	0010561	Report Period Reginning	12/01/04	Ending.	11/30/05

	Facility	Name	& ID	Number	Kno
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Knox County Nursing Home

v 8

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization		7	8 Difference:	
							Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	Percent of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		o whersing	\$	\$	15
16	V			*			T	•	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS	S			I	Page 6H
#	0010561	Report Period Beginning:	12/01/04	Ending:	11/30/05

VII.	REL	ATED	PA	RTIES	(continued))

Facility Name & ID Number

В.	Are any costs included in this report which are a result of transactions with	th rela	ated organizations?	? This includes rent,
	management fees, purchase of supplies, and so forth.		YES	NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

Knox County Nursing Home

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sched	lule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		o whereas	\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Γotal			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

		STATE OF ILLING	OIS			P	Page 6I
Facility Name & ID Number	Knox County Nursing Home	i	0010561	Report Period Beginning:	12/01/04	Ending:	11/30/05

VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions with	rela	ted organizatio	ons? I	This includes rent,
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization		7	8 Difference:	
							Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	Percent of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		o whersing	\$	\$	15
16	V			*			-	•	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

Ending:

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7	1	8	
						Average Hou	rs Per Work				
					Compensation	Week Devo	oted to this	Compensati	on Included	Schedule V.	
					Received	Facility and	and % of Total in Costs for this		s for this	Line &	
				Ownership	From Other	Work Week		Reportir	ng Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	County No Longer Holds Com	mittee Meetings Relat	ting Only To The N	ursing Hom	e. All County Meet	ings Relate T	o The Count	y	\$		1
2	As A Whole. Therefore, Per D	iems and Mileage Are	Not Separately Pa	id By The N	ursing Home.						2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10	Note - No Member Of The Co	unty Board Provided I	Direct Services To	The Nursing	Home. In Addition	n, No Board I	Member Has	Ownership I	n An Entity Tha	t	10
11	Conducted Business Transac	tions With The Nursin	g Home During Th	e Reporting	Period.						11
12											12
13								TOTAL	\$		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

SEE ACCOUNTANTS' COMPILATION REPORT

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/04 Ending: 11/30/05

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	Knox County
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	200 South Cherry Street
or parent organization costs? (See instructions.) YES X NO	City / State / Zip Code	Galesburg, IL 61401
	Phone Number	309) 345-3837
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	309) 343-7002

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	22		Direct Cost	1	1	\$	\$	1	\$ 282,159	1
2			Direct Cost	1	1			1	312,881	2
3	21	Bookkeeping & Accounting	Hours Worked	2,166	2166	25,855		2,166	25,855	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14 15										14 15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										22
24										24
25	TOTALS					\$ 25,855	\$		\$ 620,895	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home	#	0010561	Report Period Beginning:	12/01/04	Ending:	11/30/05
VIII. ALLOCATION OF INDIRECT COSTS						
			Name of Related	Organization		
A. Are there any costs included in this report which were derived from allocations of	f centr <u>al offi</u> c	e	Street Address			
or parent organization costs? (See instructions.)	NO		City / State / Zip	Code		
					()	
B. Show the allocation of costs below. If necessary, please attach worksheets.			Fax Number		()	
		e		Code	()	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•		Ü	\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13 14										13
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22 23
23										23
24										24
25	TOTALS					\$	\$		\$	25

Home	#	0010561	Report Period Beginning:	12/01/04	Ending:	11/30/05	
				Organization		_	
ere derived from allocations of central	office	e	Street Address	_	1000		
YES NO			City / State / Zip	Code			
			Phone Number		()		
ase attach worksheets.			Fax Number	7	()		
•		ere derived from allocations of central offic	ere derived from allocations of central office YES NO	Name of Related ere derived from allocations of central office YES NO City / State / Zip Phone Number	Name of Related Organization ere derived from allocations of central office Street Address YES NO City / State / Zip Code Phone Number	Name of Related Organization ere derived from allocations of central office Street Address YES NO City / State / Zip Code Phone Number	Name of Related Organization ere derived from allocations of central office Street Address YES NO City / State / Zip Code Phone Number

	1	2	3	4	5	6	7	8	9	
	Schedule V	-	Unit of Allocation	•	Number of	Total Indirect	Amount of Salary	0		
	Line						Cost Contained	Facility	Allocation	
			(i.e.,Days, Direct Cost,		Subunits Being	Cost Being		Facility		
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17 18
18										19
19 20										20
										21
21 22										21
23										22
										23
24	TOTAL C					Φ.	ф		ф	25
25	TOTALS					\$	\$		\$	25

STATE	OF	ILLI	V	o	1
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Page 8C **Report Period Beginning: Facility Name & ID Number Knox County Nursing Home** # 0010561 12/01/04 **Ending:** 11/30/05 VIII. ALLOCATION OF INDIRECT COSTS Name of Related Organization A. Are there any costs included in this report which were derived from allocations of central office **Street Address** City / State / Zip Code Phone Number or parent organization costs? (See instructions.) YES B. Show the allocation of costs below. If necessary, please attach worksheets. Fax Number

			_					ī		
	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	Reference	Item	Square rect)	Total Clits	Amocateu Among	\$	\$	Cints	\$	1
2			1			Ψ	Ψ		Ψ	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16 17										16
										17
18 19										18 19
20										20
21										21
22										22
23										22
24										24
	TOTALS		_			s	\$		s	25

STATE	OF	ILLI	V	o	1
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Page 8D **Report Period Beginning: Facility Name & ID Number Knox County Nursing Home** # 0010561 12/01/04 **Ending:** 11/30/05 VIII. ALLOCATION OF INDIRECT COSTS Name of Related Organization A. Are there any costs included in this report which were derived from allocations of central office **Street Address** City / State / Zip Code Phone Number or parent organization costs? (See instructions.) YES NO B. Show the allocation of costs below. If necessary, please attach worksheets. Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item		Total Units	Allocated Among	Allocated	in Column 6	Units		
1	Reference	item	Square Feet)	Total Units	Anocated Among	Anocated	th Column o	Units	(col.8/col.4)x col.6	1
2						Φ	Þ		Þ	1 2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21 22
23										23
24										23 24
	TOTALS					¢	\$		s	25
45	TOTALS					Φ	Φ		Φ	45

Facility Name & ID Number	Knox County Nursing Home	#	0010561	Report Period Beginning:	12/01/04	Ending:	11/30/05
VIII. ALLOCATION OF INDIR	ECT COSTS						
				Name of Related	Organization		
A. Are there any costs include	d in this report which were derived from allocations of central	offic	e	Street Address			
or parent organization cost	s? (See instructions.) YES NO			City / State / Zip	Code		
				Phone Number		()	
B. Show the allocation of costs	below. If necessary, please attach worksheets.			Fax Number		()	

	1	2	3	4	5	6	7	8	9	\top
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•		8	\$	\$		\$	1
2										2
3										3
4										4
5										5
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18 19
19 20										20
21										21
22										$\frac{21}{22}$
23										22 23
24										24
25	TOTALS					\$	\$		\$	25

								0
Facility Name & ID Number	Knox County Nursing Home	#	0010561	Report Period Beginning:	12/01/04	Ending:	11/30/05	
VIII. ALLOCATION OF INDIR	RECT COSTS							
				Name of Related	Organization			
A. Are there any costs includ	ed in this report which were derived fron	allocations of central offic	e	Street Address	_			
or parent organization cos		NO NO		City / State / Zip	Code			
•				Phone Number	-	()		
B. Show the allocation of cost	ts below. If necessary, please attach work	sheets.		Fax Number	-	()		
	¥, •				_	·		
4	2	4			_			`

	1 Schedule V	2	3 Unit of Allocation	4	5 Number of	6 Total Indirect	7 Amount of Salary	8	9	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
		Itom		Total Units	_					
1	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	1
2						Ψ	Ψ		Φ	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15 16
16 17										17
18										18
19										19
20										20
21										21
22										22
23										22
24										24
25	TOTALS					\$	\$		\$	25

								_
Facility Name & ID Number	Knox County Nursing Home	#	0010561	Report Period Beginning:	12/01/04	Ending:	11/30/05	
VIII. ALLOCATION OF INDIR	ECT COSTS							
				Name of Related (Organization			
A. Are there any costs include	d in this report which were derived from allocations of central	l offic	e	Street Address		2000		
or parent organization cost	ts? (See instructions.) YES NO			City / State / Zip (Code			
				Phone Number		()		
B. Show the allocation of costs	s below. If necessary, please attach worksheets.			Fax Number		()		

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•		Ü	\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13 14										13
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22 23
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number	Knox County Nursing Home	#	0010561	Report Period Beginning:	12/01/04	Ending:	11/30/05	-
VIII. ALLOCATION OF INDIR	ECT COSTS							
, <u></u> ,	201 00010			Name of Related	Organization			
A. Are there any costs include	d in this report which were derived from allocations of central	offic	ee	Street Address	O			
or parent organization cost				City / State / Zip	Code			
				Phone Number		()		
B. Show the allocation of costs	s below. If necessary, please attach worksheets.			Fax Number		()		

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•		Ü	\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13 14										13
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22 23
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number	Knox County Nursing Home	#	0010561	Report Period Beginning:	12/01/04	Ending:	11/30/05
VIII. ALLOCATION OF INDIR	ECT COSTS			-			
				Name of Related	Organization		
A. Are there any costs include	ed in this report which were derived from allocations of centra	l offic	e	Street Address	_		
or parent organization cos	ts? (See instructions.) YES NO			City / State / Zip	Code		
	· · · · · · · · · · · · · · · · · · ·			Phone Number		()	
B. Show the allocation of cost	s below. If necessary, please attach worksheets.			Fax Number	-	()	

	1	2	3	4	5	6	7	8	9	\top
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•		8	\$	\$		\$	1
2										2
3										3
4										4
5										5
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18 19
19 20										20
21										21
22										$\frac{21}{22}$
23										22 23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/04 Ending: 11/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES NO		Monthly Payment Required	Date of Note	Amo Original	unt of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related				•					•	
	Long-Term										
1	Greatamerica Leasing Corp	X	Computer Equipment	\$855.46	3/2003	\$ 23,351	\$ 1,803	3/2006	0.1708	\$ 1,939	1
2	Office Specialists Inc	X	Copier	\$243.41	9/2004	12,678	9,390	9/2009	0.0571	166	2
3											3
4											4
5	See Supplemental Schedule										5
	Working Capital										
6											6
7											7
8	See Supplemental Schedule										8
9	TOTAL Facility Related B. Non-Facility Related*	-		\$1,098.87		\$ 36,029	\$ 11,193			\$ 2,105	9
10	Interest Income	X								(2,105)	10
11											11
12											12
13	See Supplemental Schedule										13
14	TOTAL Non-Facility Related					\$	\$			\$ (2,105)	14
15	TOTALS (line 9+line14)					\$ 36,029	\$ 11,193			\$	15

¹⁶⁾ Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Knox County Nursing Home STATE OF ILLINOIS Page 9 - SUPPLEMENTAL Report Period Beginning: 12/01/04 Ending: 11/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10	
				Monthly				Maturity	Interest	Reporting Period	
	Name of Lender	Related**	Purpose of Loan	Payment	Date of		ınt of Note	Date	Rate	Interest	
		YES NO)	Required	Note	Original	Balance		(4 Digits)	Expense	
	A. Directly Facility Related										
	Long-Term										
1						\$	\$			\$	1
2											2
3											3
4											4
5											5
6											6
7	TOTAL Long-Term										7
	Working Capital										
8						\$	\$			\$	8
9											9
10											10
11											11
12											12
13											13
14	TOTAL Working Capital										14
	B. Non-Facility Related*										
15						\$	\$			\$	15
16											16
17											17
18											18
19											19
20	TOTAL Non-Facility Related										20

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10
0010561 Report Period Beginning: 12/01/04 Ending: 11/30/05

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/04 Ending:

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

	Inches and and an Inches	and the constitute about UDC T	The second	-1-1-1-1		
	li ni	see the next worksheet, "RE_T	ax". The real of	estate tax statement and		
1. Real Estate Tax accrual used on 2004 report.	biii must accompan	y the cost report.			\$	1
2. Real Estate Taxes paid during the year: (Indi	cate the tax year to which this payr	ment applies. If payment covers more	than one year, de	tail below.)	\$	2
3. Under or (over) accrual (line 2 minus line 1)					\$	3
4. Real Estate Tax accrual used for 2005 report	. (Detail and explain your calculati	ion of this accrual on the lines below.	.)		\$	4
5. Direct costs of an appeal of tax assessments						
(Describe appeal cost below. Attac	n copies of invoices to sup	port the cost and a copy of the	ne appear med	i with the county.)	\$	5
6. Subtract a refund of real estate taxes. You m	wat offeet the full amount of any di	ine at ammed as ata				
		reci addear cosis				
	•	rrect appear costs				
classified as a real estate tax cost plus one-ha	lf of any remaining refund.	••	ate tax appeal	board's decision.)	\$	
classified as a real estate tax cost plus one-ha TOTAL REFUND \$ F	or Tax Year.	Attach a copy of the real esta	ate tax appeal	board's decision.)	\$	
classified as a real estate tax cost plus one-ha	or Tax Year.	Attach a copy of the real esta	ate tax appeal	board's decision.)	\$ \$	
classified as a real estate tax cost plus one-ha TOTAL REFUND \$ F	or Tax Year.	Attach a copy of the real esta	ate tax appeal	board's decision.)	\$ \$	
classified as a real estate tax cost plus one-hat TOTAL REFUND \$ FO	or Tax Year. (le V, line 33. This should be a con	Attach a copy of the real estanbination of lines 3 thru 6.	ate tax appeal	board's decision.) FOR OHF USE ONLY	\$ \$	
classified as a real estate tax cost plus one-hat TOTAL REFUND \$ Formula 7. Real Estate Tax expense reported on Schedul Real Estate Tax History:	or Tax Year. (le V, line 33. This should be a con	Attach a copy of the real esta	ate tax appeal		\$ \$ FOR 2004 \$	7
classified as a real estate tax cost plus one-hat TOTAL REFUND \$ Formula 7. Real Estate Tax expense reported on Schedul Real Estate Tax History:	or Tax Year. (le V, line 33. This should be a con 2000 2001	Attach a copy of the real estanbination of lines 3 thru 6.		FOR OHF USE ONLY		1.
classified as a real estate tax cost plus one-hat TOTAL REFUND \$ Formula 7. Real Estate Tax expense reported on Schedul Real Estate Tax History:	If of any remaining refund. Tax Year. (V, line 33. This should be a come of the V, line 33. This should be a come of the V, line 34. This should be a come of the V, line 35. This should be a come of the V, line 36. This should be a come of the V, line 36. This should be a come of the V, line 36. This should be a come of the V, line 36. This should be a come of the V, line 36. This should be a come of the V, line 36. This should be a come of the V, line 37. This should be a come of the V, line 38. This should be a come of	Attach a copy of the real estanbination of lines 3 thru 6.	13 14	FOR OHF USE ONLY FROM R. E. TAX STATEMENT PLUS APPEAL COST FROM LI		1:
classified as a real estate tax cost plus one-hat TOTAL REFUND \$ For a state Tax expense reported on Schedu Real Estate Tax History: Real Estate Tax Bill for Calendar Year:	If of any remaining refund. Tax Year. (V, line 33. This should be a come of the V, line 33. This should be a come of the V, line 34. This should be a come of the V, line 35. This should be a come of the V, line 36. This should be a come of the V, line 36. This should be a come of the V, line 36. This should be a come of the V, line 36. This should be a come of the V, line 36. This should be a come of the V, line 36. This should be a come of the V, line 37. This should be a come of the V, line 38. This should be a come of	Attach a copy of the real estanbination of lines 3 thru 6.	13	FOR OHF USE ONLY FROM R. E. TAX STATEMENT		1: 1:

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME	Knox County Nu	rsing Home			COUNTY	Knox	
FAC	ILITY IDPH LICI	ENSE NUMBER	0010561		_			
CON	TACT PERSON	REGARDING THI	S REPORT	Steve Lavenda				
TEL	EPHONE (847)2	36-1111	-	FAX #:	(847)236-11	155		
A.	Summary of Re	al Estate Tax Cost	i					
	cost that applies home property w	to the operation of hich is vacant, rent	the nursing he ed to other or	essed for 2004 on the ome in Column D. Ro ganizations, or used f y period other than ca	eal estate tax or purposes o	applicable to ther than lor	any portion	of the nursing
	(A	.)		(B)		(C)		(D)
1.	Tax Index	Number		erty Description		<u>Total Tax</u>	<u> </u>	Tax Applicable to Nursing Hom
2.								
3.							_ \$	
4.							_ \$	
5.								
6.							_ \$	
7.							_ \$	
8.								
9.					- \$_		_ \$.	
10.							_ \$.	
				TOTALS	\$		\$	
B.	Real Estate Tax	Cost Allocations						
	Does any portion used for nursing		y to more tha	n one nursing home, YES	vacant proper NO	ty, or proper	ty which is	not directly
				shows the calculation				nome.

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004

C. Tax Bills

tax bill which is normally paid during 2005.

Page 10A

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	CILITY NAME Knox County N	ursing Home	COUNTY	Knox
FAC	CILITY IDPH LICENSE NUMBER	0010561	_	
CON	NTACT PERSON REGARDING TH	IS REPORT Steve Lavenda		
TEL	EPHONE (847)236-1111	FAX #:	(847)236-1155	
A.	Summary of Real Estate Tax Cos			
	cost that applies to the operation of home property which is vacant, ren	l estate tax assessed for 2004 on the the nursing home in Column D. Reted to other organizations, or used fide cost for any period other than cal	al estate tax applicable to or purposes other than lo	any portion of the nursing
	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Hom</u>
1.			\$	\$
2.			\$	
3.			\$	\$
4.			\$	
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	
9.			\$	\$
10.			\$	_ \$
		TOTALS	\$	\$
B.	Real Estate Tax Cost Allocations			
	Does any portion of the tax bill appused for nursing home services?	oly to more than one nursing home, v		rty which is not directly
		schedule which shows the calculation must be allocated to the nursing hom-		

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which

C. Tax Bills

is normally paid during 2005.

Page 10B

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.) D. Does the Operating Entity?				\mathbf{S}'	TATE OF ILLINO	IS			Page 11
A. Square Feet: 100,375 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1 C. Does the Operating Entity? X (a) Own the Facility (b) Rent from a Related Organization.					# 0010561	Report Period Beginn	ning: 12/	01/04 Ending:	
C. Does the Operating Entity?	K. BU	UILDING AND GENERAL INFORMA	ATION:						
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XII-A. See instructions.) D. Does the Operating Entity? X (a) Own the Equipment	A.	Square Feet: 100,375	B. General Construction Type:	Exterior B	rick	Frame Steel	Number	of Stories	1
D. Does the Operating Entity? X (a) Own the Equipment	C.	Does the Operating Entity?	X (a) Own the Facility	(b) Rent from a I	Related Organizatio	on.			elated
Unrelated Organization. Unrelated Organizatio		(Facilities checking (a) or (b) must co	omplete Schedule XI. Those checking ((c) may complete Schedule	XI or Schedule XII	-A. See instructions.)			
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.) E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable). NA F. Does this cost report reflect any organization or pre-operating costs which are being amortized? If so, please complete the following: 1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred: Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.) GL OWNERSHIP COSTS: A. Land. 1	D.	Does the Operating Entity?	X (a) Own the Equipment	(b) Rent equipme	ent from a Related	Organization.			pletely
(Such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable). N/A F. Does this cost report reflect any organization or pre-operating costs which are being amortized? If so, please complete the following: 1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.) GI. OWNERSHIP COSTS: A. Land. 1 2 3 4 Use Square Feet Year Acquired Cost 1 Facility 1,481,040 1966 156,600 1 2		(Facilities checking (a) or (b) must co	omplete Schedule XI-C. Those checkin	g (c) may complete Schedu	le XI-C or Schedule	e XII-B. See instructions		g	
If so, please complete the following: 1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: A. Dates Incurred: Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.) XI. OWNERSHIP COSTS: 1 2 3 4 A. Land. Use Square Feet Year Acquired Cost 1 Facility 1,481,040 1966 156,600 1 2	Е.	(such as, but not limited to, apartment List entity name, type of business, sq	nts, assisted living facilities, day traini	ng facilities, day care, inde <mark>j</mark>	endent living facili				
If so, please complete the following: 1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: A. Dates Incurred: Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.) XI. OWNERSHIP COSTS: 1 2 3 4 A. Land. Use Square Feet Year Acquired Cost 1 Facility 1,481,040 1966 156,600 1 2									
If so, please complete the following: 1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: A. Dates Incurred: Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.) XI. OWNERSHIP COSTS: 1 2 3 4 A. Land. Use Square Feet Year Acquired Cost 1 Facility 1,481,040 1966 156,600 1 2									
3. Current Period Amortization: A. Dates Incurred:	F.		nnization or pre-operating costs which	are being amortized?		YES	X NO		
Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.) XI. OWNERSHIP COSTS: 1 2 3 4 A. Land. Use Square Feet Year Acquired Cost 1 Facility 1,481,040 1966 \$ 156,600 1 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.	. Total Amount Incurred:		2.	Number of Years	Over Which it is Being A	amortized:		
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.) A. Land. A. Land. Square Feet Year Acquired Cost Cost	3.	. Current Period Amortization:		4.	Dates Incurred:			,	
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.) A. Land. A. Land. Square Feet Year Acquired Cost Cost			N. d. and C. Cardan						
A. Land. 1 2 3 4 A. Land. Use Square Feet Year Acquired Cost 1 Facility 1,481,040 1966 \$ 156,600 1 2 2 2 2 2 2 2 2 2 2				etailing the total amount of	organization and p	re-operating costs.)			
A. Land. 1 2 3 4			F	6	g r	1 • • • • • • • • • • • • • • • • • • •			
A. Land. Use Square Feet Year Acquired Cost Facility	XI. C	OWNERSHIP COSTS:	1	2	2	4			
1 Facility 1,481,040 1966 \$ 156,600 1 2		A. Land.	Use	-		Cost			
				<u> </u>			600 1		
			2 3 TOTALS	1,481,040		A	600 3		

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 12 11/30/05 Facility Name & ID Number **Knox County Nursing Home Report Period Beginning:** 0010561 12/01/04 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

			3 4 5			6	7	8	9		
	FOR BHF USE ONLY Year		Year		Current Book	Life	Straight Line Depreciation		Accumulated		
	Beds*	Beds* Acquired		Constructed	Cost	Depreciation	Depreciation in Years		Adjustments	Depreciation	
4	204		1966	1966	\$ 1,842,192	\$	50	\$ 36,844	\$ 36,844	\$ 1,446,204	4
5											5
6											6
7											7
8											8
	Impro	ovement Type**	_								
9	Various	· ·		1966	46,724		20	934	934	35,855	9
10	Various			1971	146,065		20			146,065	10
11	Various			1980	9,972		20			9,972	11
	Various			1981	650		20			650	12
13	Various			1983	14,762		20			14,762	13
14	Various			1984	31,009		20	1,550	1,550	30,783	14
15	Various			1985	73,090		20			73,090	15
16	Various			1986	141,506		20			141,506	16
17	Various			1987	142,693		20			142,693	17
	Various			1988	60,820		20	3,041	3,041	55,050	18
19	Various			1989	47,469		20	3,165	3,165	39,582	19
	Various			1990	29,117		20	1,456	1,456	19,983	20
	Various			1991	17,547		20	7.004	7 204	17,547	21
	Various			1992	197,932		20	6,294	6,294	197,932	22
	Various			1993	97,234		20	6,482	6,482	46,047	23
	Various Various			1994 1995	45,232 58,215		20	3,848	3,848	45,232 58,215	24 25
	Various			1995	76,390		20 20	5,093	5,093	57,943	26
				1997	26,377		20	951	951	26,377	27
28			1998	39,334		20	2,319	2,319	20,858	28	
29	Various			1999	21,237		20	1,529	1,529	11,056	29
30				2000	20,496		20	2,050	2,050	11,913	30
				2001	1,395		20	140	140	572	31
32			2001	1,070			170	170	312	32	
33										33	
34											34
35											35
36				1			1				36
					1			1		1	1

^{*}Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total SEE ACCOUNTANTS' COMPILATION REPORT

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12A 11/30/05 STATE OF ILLINOIS Facility Name & ID Number **Knox County Nursing Home Report Period Beginning:** 0010561 12/01/04 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58 59								58 59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67 Related Building Company (Pages 12-BLDG & 12A-BLD)	<u>C)</u>							67
68 Related Party Allocations (Pages 12-BEDG & 12A-BED)	U)							68
69 Financial Statement Depreciation			193,337			(193,337)		69
 Financial Statement Depreciation TOTAL (lines 4 thru 69) 		\$ 3,187,458	\$ 193,337		\$ 75,696		\$ 2,649,887	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12B 11/30/05 Facility Name & ID Number **Knox County Nursing Home Report Period Beginning:** 0010561 12/01/04 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 3,187,458	\$ 193,337		\$ 75,696	\$ (117,641)	\$ 2,649,887	1
2 Architect Fees - Boiler Work	2003	11,412		20	571	571	1,427	2
3 Boiler Replacement & Upgrade	2003	80,229		20	4,011	4,011	10,028	3
4 Asbestos Inspections	2003	9,825		20	491	491	1,257	4
5 Architect - Toilet & Bathing Rooms	2003	1,916		20	96	96	246	5
Framing, Drywall, Plumbing, Finishing - Handicap Bathrooms	2003	26,549		20	1,327	1,327	3,397	6
7 Bathroom Fixtures, Hand Rails	2003	3,819		20	382	382	955	7
8 Tub	2003	3,895		20	390	390	975	8
9 Architect - Hospice Wing	2003	4,480		20	224	224	560	9
10 Hospice - Minor Renovation, Drywall, Wall Coverings	2003	5,256		20	263	263	877	10
11 Wall Coverings, Drywall, Minor Renovation	2003	10,264		20	513	513	1,283	11
12 Garden Room Doors	2003	1,691		20	85	85	212	12
13 A/C Parts	2003	1,904		20	95	95	95	13
14 Architect - Remodel Rooms	2004	22,273		20	1,114	1,114	1,671	14
15 Hospice - Minor Renovation	2004	3,379		20	169	169	253	15
16 Bathroom Upgrade	2004	3,566		20	178	178	267	16
17 Condensing Unit	2004	9,182		20	918	918	1,377	17
18 Fire Doors	2004	11,238		20	1,124	1,124	1,686	18
19 Fire Alarm	2004	1,516		20	76	76	114	19
20 Sealcoating	2004	18,167		20	908	908	1,362	20
21 Call Light Cords	2004	2,163		20	108	108	162	21
22 Door Locks	2004	2,864		20	143	143	286	22
New Condensing Unit	2004	8,933		20	447	447	447	23
24 Fire Alarm System	2004	725		20	36	36	36	24
25 Air Handler - Fire Alarm	2004	2,483		20	124	124	124	25
26 Fire Doors	2004	4,230		20	212	212	212	26
27 Door	2004	1,352		20	68	68	68	27
28 Fire Door Installation	2004	4,500		20	225	225	225	28
29 Awning	2004	431		20	22	22	22	29
30 Steam Distributing Coil	2004	1,715		20	86	86	86	30
31 Hvac	2004	5,900		20	295	295	295	31
32 Renovation	2004	2,168		20	108	108	108	32
33 Renovation	2004	290		20	14	14	14	33
34 TOTAL (lines 1 thru 33)		\$ 3,455,773	\$ 193,337		\$ 90,519	\$ (102,818)	\$ 2,680,014	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12C 11/30/05 Facility Name & ID Number **Knox County Nursing Home Report Period Beginning:** 12/01/04 Ending: 0010561

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 3,455,773	\$ 193,337		\$ 90,519	\$ (102,818)	\$ 2,680,014	1
2 Freight Elevator	2004	6,029		20	301	301	301	2
3 Resurface Parking Lot	2004	18,167		20	908	908	908	3
4 Architect	2004	3,224		20	161	161	161	4
5 Cement Fire Lane	2005	300		20	15	15	15	5
6 Faucets	2005	3,915		20	196	196	196	6
7 Signage	2005	1,634		20	82	82	82	7
8 Ejector Pump	2005	6,240		20	312	312	312	8
9 Phone System	2005	2,177		20	109	109	109	9
10 Architect	2005	480		20	24	24	24	10
11 Wallcovering	2005	435		20	22	22	22	11
12 Smoke Dampers	2005	590		20	30	30	30	12
13 Drapery	2005	3,129		20	156	156	156	13
14 Wallcovering	2005	1,935		20	97	97	97	14
15 Flush Valve Converter	2005	636		20	32	32	32	15
16 Cooling Tower	2005	32,196		20	1,610	1,610	1,610	16
17 Elevator Upgrade	2005	32,880		20	1,644	1,644	1,644	17
18 Remodeling / Redecorating	2005	170,256		20	8,513	8,513	8,513	18
19 Remodeling / Redecorating	2005	4,688		20	234	234	234	19
20 Garbage Disposer*	2005	1,994		20	100	100	100	20
21 Smoke Damper*	2005	5,310		20	266	266	266	21
Gauge Assembly For Boiler*	2005	830		20	41	41	41	22
23 Verticle Mt Emergenchshower And Other Inv*	2005	1,456		20	73	73	73	23
24 Wall Covering W 2*	2005	311		20	16	16	16	24
25 Water Chiller*	2005	549		20	27	27	27	25
26 Smoke Detecter*	2005	328		20	16	16	16	26
Faucets W-2*	2005	637		20	32	32	32	27
28 Boiler Repair*	2005	1,244		20	62	62	62	28
29 Architect*	2005	400		20	20	20	20	29
30 Draperies Wing 2*	2005	3,095		20	155	155	155	30
31 Chiller*	2005	3,202		20	160	160	160	31
32 Cabinets For Main Dining Room*	2005	637		20	32	32	32	32
33 Chiller Work*	2005	622		20	31	31	31	33
34 TOTAL (lines 1 thru 33)		\$ 3,765,297	\$ 193,337		\$ 105,995	\$ (87,342)	\$ 2,695,490	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12D 11/30/05 Facility Name & ID Number **Knox County Nursing Home Report Period Beginning:** 0010561 12/01/04 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 3,765,297	\$ 193,337		\$ 105,995	\$ (87,342)	\$ 2,695,490	1
2 Drapes & Hardware W-2*	2005	1,277		20	64	64	64	2
3 Door Alarm*	2005	203		20	10	10	10	3
4 Door Closers*	2005	311		20	16	16	16	4
5 Chiller Work*	2005	18,625		20	931	931	931	5
6 2 Ea Handicap Door Openers*	2005	3,507		20	175	175	175	6
7 Architect*	2005	960		20	48	48	48	7
8 2 Cabinets	2005	2,417		20	121	121	121	8
9 Set 4 Laminate Panels*	2005	1,024		20	51	51	51	9
10 Remove And Replace Concrete*	2005	600		20	30	30	30	10
11 Drapery Rods W-2*	2005	324		20	16	16	16	11
12 Drapery Rods W-2*	2005	344		20	17	17	17	12
13 Wiring For Outside Lights*	2005	1,027		20	51	51	51	13
14 Plan Review*	2005	6,000		20	300	300	300	14
15 Architect*	2005	800		20	40	40	40	15
16 Oxygen Room Door*	2005	349		20	17	17	17	16
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27 28								27
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32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,803,064	\$ 193,337		\$ 107,883	\$ (85,454)	\$ 2,697,378	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12E 11/30/05 Facility Name & ID Number **Knox County Nursing Home Report Period Beginning:** 0010561 12/01/04 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	\top
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 3,803,064	\$ 193,337		\$ 107,883	\$ (85,454)	\$ 2,697,378	1
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33		2 002 0 5	102.225		405000	* (OF 15 *)	A (0= 2=0	33
34 TOTAL (lines 1 thru 33)		\$ 3,803,064	\$ 193,337		\$ 107,883	\$ (85,454)	\$ 2,697,378	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12F 11/30/05 STATE OF ILLINOIS Facility Name & ID Number **Knox County Nursing Home Report Period Beginning:** 0010561 12/01/04 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9 1 1	
	Year	a .	Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12E, Carried Forward		\$ 3,803,064	\$ 193,337		\$ 107,883	\$ (85,454)	\$ 2,697,378	1
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32 33								32
34 TOTAL (lines 1 thru 33)		\$ 3,803,064	\$ 193,337		\$ 107,883	\$ (85,454)	\$ 2,697,378	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12G 11/30/05 STATE OF ILLINOIS Facility Name & ID Number **Knox County Nursing Home Report Period Beginning:** 0010561 12/01/04 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
*	Year	G 4	Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12F, Carried Forward		\$ 3,803,0	\$ 193,337		\$ 107,883	\$ (85,454)	\$ 2,697,378	1
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30				1				30
31				1				31
32 33				1				32
34 TOTAL (lines 1 thru 33)		\$ 3,803,0	064 \$ 193,337		1	\$ (85,454)	\$ 2,697,378	33

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12H 11/30/05 Facility Name & ID Number **Knox County Nursing Home Report Period Beginning:** 0010561 12/01/04 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
T ATT NOT	Year	G 4	Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	4
1 Totals from Page 12G, Carried Forward		\$ 3,803,064	\$ 193,337		\$ 107,883	\$ (85,454)	\$ 2,697,378	1
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34 TOTAL (lines 1 thru 33)		\$ 3,803,064	\$ 193,337		\$ 107,883	\$ (85,454)	\$ 2,697,378	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12I 11/30/05 Facility Name & ID Number **Knox County Nursing Home Report Period Beginning:** 0010561 12/01/04 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

I	3	4	5	6	7	8	9	Т
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12H, Carried Forward		\$ 3,803,064	\$ 193,337		\$ 107,883	\$ (85,454)	\$ 2,697,378	1
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32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,803,064	\$ 193,337		\$ 107,883	\$ (85,454)	\$ 2,697,378	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12J 11/30/05 STATE OF ILLINOIS Facility Name & ID Number **Knox County Nursing Home Report Period Beginning:** 0010561 12/01/04 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	T
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12I, Carried Forward		\$ 3,803,064	\$ 193,337		\$ 107,883	\$ (85,454)	\$ 2,697,378	1
2								2
3								3
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31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,803,064	\$ 193,337		\$ 107,883	\$ (85,454)	\$ 2,697,378	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12K 11/30/05 STATE OF ILLINOIS Facility Name & ID Number **Knox County Nursing Home Report Period Beginning:** 0010561 12/01/04 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	T
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12J, Carried Forward		\$ 3,803,064	\$ 193,337		\$ 107,883	\$ (85,454)	\$ 2,697,378	1
2								2
3								3
4								4
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34 TOTAL (lines 1 thru 33)		\$ 3,803,064	\$ 193,337		\$ 107,883	\$ (85,454)	\$ 2,697,378	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12-BLDG 11/30/05 STATE OF ILLINOIS **Report Period Beginning:** 12/01/04 Ending: 0010561

Facility Name & ID Number XI. OWNERSHIP COSTS (continued)

Knox County Nursing Home

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	ng Depreciation-Including Fixed Equip	2	3	4	5	6	7	8	9	Т
	-	FOR OHF USE ONLY	Year	Year	•	Current Book	Life	Straight Line		Accumulated	
	Beds*	1011 0111 002 01121	Acquired	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
4					\$	\$		\$	\$	\$	4
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	Impro	vement Type**									
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28 29											28 29
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33											33
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35											35
36											36

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS
0010561 Report Period Beginning: 12/01/04 Ending: Page 12A-BLDG 11/30/05

Facility Name & ID Number Knox County Nursing Home

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

B. Building Depreciation-Including Fixed Equipment. (See instr	1 3	4	5 Tollar .	6	7	8	1 9	
1	Year	7	Current Book	Life	Straight I inc		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation 1	in Years	Straight Line Depreciation	Adjustments	Depreciation	
37		\$	\$	III T Cars	e Depreciation	Aujustinents	e Depreciation	37
		Φ	Ф		Þ	Ф	Ф	
38								38
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63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12-REP 11/30/05 Facility Name & ID Number **Knox County Nursing Home Report Period Beginning:** 12/01/04 Ending: 0010561

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	The Depreciation-including Fixed Equip.	2	3	4	5	6	7	8	9	T
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Impr	ovement Type**	•								
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^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12A-REP 11/30/05 STATE OF ILLINOIS Facility Name & ID Number **Knox County Nursing Home Report Period Beginning:** 0010561 12/01/04 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	T
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
37		\$	\$		\$	\$	\$	37
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44								44
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46								46
47								47
48								48
49								49
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57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64 65
65								66
66 67								67
68								68
69								69
		¢	¢.		¢	6	φ	
70 TOTAL (lines 4 thru 69)		\$	\$		Þ	\$	\$	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 13 Facility Name & ID Number **Knox County Nursing Home Report Period Beginning:** 11/30/05 0010561 12/01/04 **Ending:**

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of	1	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 675,054	\$	\$ 67,505	\$ 67,505	10	\$ 337,030	71
72	Current Year Purchases	99,217		9,901	9,901	10	9,901	72
73	Fully Depreciated Assets	327,648				10	327,648	73
74								74
75	TOTALS	\$ 1,101,919	\$	\$ 77,406	\$ 77,406		\$ 674,579	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76	Facility	VAN	2005	\$ 43,984	\$	\$ 8,797	\$ 8,797	5	\$ 8,797	76
77	Facility	VAN	2005	34,452		6,890	6,890	5	6,890	77
78	Facility	Ford Escort Wagon	1993	10,827				5	10,827	78
79	Facility	Ford Truck	1995	17,024				5	17,024	79
80	TOTALS			\$ 106,287	\$	\$ 15,687	\$ 15,687		\$ 43,538	80

E. Summary of Care-Related Assets

		Reference	Amount		
8	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,167,869	81	
8	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 193,337	82	
8.	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 200,977	83	*:
8	4 Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,640	84	
8	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,415,496	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

Faci	lity Name & Il	D Number	Knox County !	Nursing Home		STATE OF ILLINOIS # 0010561		Period Beginning:	12/01/04	Ending:	Page 14 11/30/05
XII.	1. Name of l 2. Does the f	nd Fixed Equ Party Holding	ay real estate taxes i	,	l amount shown below on]NO				
		1	2	3	4	5	6				
		Year Constructe	Number ed of Beds	Original Lease Date	Rental Amount	Total Years of Lease	Total Years Renewal Option*				
	Original	Constructi	d of Beus	Lease Date	Amount	of Lease	Kenewai Option	10. Effect	tive dates of curren	t rental agree	ment:
3	Building:				\$				ing		
4	Additions							4 Ending	g		
5								5			
6	TOTAL								to be paid in future l agreement:	years under	the current
	This amo	unt was calcu ngth of the lea _	ortization of lease extends the lated by dividing the lase			*		Fiscal 12 13 14.	/2006 /2007 /2008	Annual R	ent
	B. Equipmen 15. Is Moval 16. Rental A	t-Excluding T ble equipmen amount for m	Transportation and I trental included in ovable equipment:	Fixed Equipment. (building rental?		See Attached Schedule		adown of movable eq		<u> </u>	
	C. Vehicle Re	entai (See inst	ructions.)		3	4					
	_		Model Year		Monthly Lease	Rental Expense					
L_	Use		and Make		Payment	for this Period			nere is an option to		
17 18	 			\$		\$	17	_	se provide complet edule.	e details on a	tached
19	 						19	SCII	cuuic.		
20							20	** <u>Thi</u>	s amount plus any a	mortization o	of lease
21	TOTAL			\$		\$	21	exp	ense must agree wit	h page 4, line	<u>34.</u>

	nge 15 11/30/05
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)	
A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)	
A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)	
1. HAVE YOU TRAINED CNAS YES 2. CLASSROOM PORTION: 3. CLINICAL PORTION:	ŀ
DURING THIS REPORT	
PERIOD? X NO IN-HOUSE PROGRAM IN-HOUSE PROGRAM	ļ
IN OTHER FACILITY IN OTHER FACILITY	
If "yes", please complete the remainder	
of this schedule. If "no", provide an COMMUNITY COLLEGE HOURS PER CNA	ļ
explanation as to why this training was	
not necessary. HOURS PER CNA	
B. EXPENSES C. CONTRACTUAL INCOME	
ALLOCATION OF COSTS (d)	
In the box below record the amount of incom	
1 2 3 4 facility received training CNAs from other fa	cilities.
Facility The last of the last	
Drop-outs Completed Contract Total \$	
1 Community College Tuition \$ \$ \$	
2 Books and Supplies D. NUMBER OF CNAs TRAINED	
3 Classroom Wages (a) 4 Clinical Wages (b) COMPLETED	
5 In-House Trainer Wages (c) 1. From this facility 2. From other facilities (f)	
6 Transportation 2. From other facilities (f) 7 Contractual Payments DROP-OUTS	
8 CNA Competency Tests 1. From this facility	
9 TOTALS \$ \$ \$ 2. From other facilities (f)	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(e)

SUM OF line 9, col. 1 and 2

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

TOTAL TRAINED

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

0010561 Report Period Beginning:

12/01/04 Ending:

Page 16 11/30/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
		Schedule V	Staff	Î	Outside	e Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other th	nan consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. $3 + 5 + 6$)	
1	Licensed Occupational Therapist	39 - 02	hrs	\$		\$	\$ 118,561		\$ 118,561	1
	Licensed Speech and Language									
2	Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy	39 - 02	prescrpts				151,975		151,975	9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						19,302		19,302	13
14	TOTAL			\$		\$	\$ 289,838		\$ 289,838	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **Knox County Nursing Home** XV. BALANCE SHEET - Unrestricted Operating Fund.

0010561 As of 11/30/05

Report Period Beginning: (last day of reporting year) **Ending:**

This report must be completed even if financial statements are attached.

	This report must be completed even	1		2 After	
		О	perating	Consolidation*	
	A. Current Assets	Φ.	450.000	I.b.	1 4
1	Cash on Hand and in Banks	\$	152,929	\$	1
2	Cash-Patient Deposits		19,264		2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance)		687,566		3
4	Supply Inventory (priced at)		22,937		4
5	Short-Term Investments				5
6	Prepaid Insurance				6
7	Other Prepaid Expenses				7
8	Accounts Receivable (owners or related parties)				8
9	Other(specify): See Attached Schedule				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	882,696	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments		30,000		12
13	Land				13
14	Buildings, at Historical Cost				14
15	Leasehold Improvements, at Historical Cost		5,180,716		15
16	Equipment, at Historical Cost				16
17	Accumulated Depreciation (book methods)		(3,578,261)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify): See Attached Schedule		1,373,881		23
	TOTAL Long-Term Assets		-		
24	(sum of lines 11 thru 23)	\$	3,006,336	\$	24
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	3,889,032	\$	25

		1 Op	erating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	158,473	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits		18,350		28
29	Short-Term Notes Payable		11,193		29
30	Accrued Salaries Payable		355,998		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		5,000		31
32	Accrued Real Estate Taxes(Sch.IX-B)				32
33	Accrued Interest Payable				33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	See Attached Schedule		28,750		36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	577,764	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable				40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43	See Attached Schedule				43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$		\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	577,764	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$	3,311,268	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$	3,889,032	\$	48

Page 18 11/30/05 STATE OF ILLINOIS 0010561 **Report Period Beginning:** 12/01/04 **Ending:**

	IANGES IN EQUITY		1	T	1
			Total		
1	Balance at Beginning of Year, as Previously Reported	\$	3,499,904	1	1
2	Restatements (describe):			2	1
3	Adjustments Subsequent To Prior Year Cost Report		(368,092)	3	1
4				4	1
5				5	
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	3,131,812	6	
	A. Additions (deductions):				
7	NET Income (Loss) (from page 19, line 43)		179,456	7]
8	Aquisitions of Pooled Companies			8	
9	Proceeds from Sale of Stock			9	
10	Stock Options Exercised			10]
11	Contributions and Grants			11]
12	Expenditures for Specific Purposes			12]
13	Dividends Paid or Other Distributions to Owners	()	13	1
14	Donated Property, Plant, and Equipment			14	
15	Other (describe)			15	
16	Other (describe)			16	
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	179,456	17	
	B. Transfers (Itemize):				
18				18	
19				19	
20				20	
21				21	
22				22	
23	TOTAL Transfers (sum of lines 18-22)	\$		23	
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	3,311,268	24	*

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

-

	Revenue		Amount	
	A. Inpatient Care			
1	Gross Revenue All Levels of Care	\$	6,074,840	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	6,074,840	3
	B. Ancillary Revenue			
4	Day Care		869	4
5	Other Care for Outpatients			5
6	Therapy			6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	869	8
	C. Other Operating Revenue			
9	Payments for Education			9
10	Other Government Grants			10
11	CNA Training Reimbursements			11
12	Gift and Coffee Shop			12
13	Barber and Beauty Care		675	13
14	Non-Patient Meals			14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs			17
18	Sale of Supplies to Non-Patients			18
19	Laboratory			19
20	Radiology and X-Ray			20
21	Other Medical Services			21
22	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	675	23
	D. Non-Operating Revenue			
24	Contributions			24
25	Interest and Other Investment Income***		35,399	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	35,399	26
	E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)			27
28	See Supplemental Schedule		642,899	28
28a				28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	642,899	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$	6,754,682	30
_		_		

CVCIIC	ac against expense.	2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,607,649	31
32	Health Care	3,140,169	32
33	General Administration	1,205,739	33
	B. Capital Expense		
34	Ownership	197,962	34
	C. Ancillary Expense		
35	Special Cost Centers	312,017	35
36	Provider Participation Fee	111,690	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,575,226	40
41	Income before Income Taxes (line 30 minus line 40)**	179,456	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 179,456	43

*	This must	agree with	page 4.	line 45.	column 4.
---	-----------	------------	---------	----------	-----------

Report Period Beginning:

** Does this agree with taxable income (loss) per Federal Income
Tax Return? N/A If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Knox County Nursing Home**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the			e separately (В. С	CONSULTANT SERVICES	
	1	2**	3	4				
	# of Hrs.	# of Hrs.	Reporting Period	Average				Nι
	Actually	Paid and	Total Salaries,	Hourly				O
	Worked	Accrued	Wages	Wage				Pa
1 Director of Nursing	2,080	2,820	\$ 76,397	\$ 27.09	1			Ac
2 Assistant Director of Nursing	2,080	2,207	54,018	24.48	2	35	Dietary Consultant	
3 Registered Nurses	6,566	8,260	185,453	22.45	3	36	Medical Director	Mon
4 Licensed Practical Nurses	39,925	45,818	766,159	16.72	4	37	Medical Records Consultant	Mor
5 CNAs & Orderlies	114,413	130,541	1,657,214	12.69	5	38	Nurse Consultant	Flat
6 CNA Trainees					6	39	Pharmacist Consultant	Mon
7 Licensed Therapist					7	40	Physical Therapy Consultant	
8 Rehab/Therapy Aides					8		Occupational Therapy Consultant	
9 Activity Director	2,080	2,572	30,992	12.05	9	42	Respiratory Therapy Consultant	
10 Activity Assistants	4,548	4,995	45,725	9.15	10		Speech Therapy Consultant	
11 Social Service Workers	7,314	8,155	105,051	12.88	11		Activity Consultant	
12 Dietician					12	45	Social Service Consultant	
13 Food Service Supervisor	2,080	2,244	27,642	12.32	13	46	Other(specify)	
14 Head Cook	12,383	15,345	147,159	9.59	14	47		
15 Cook Helpers/Assistants	17,489	18,888	156,665	8.29	15	48		
16 Dishwashers					16			
17 Maintenance Workers	6,858	7,696	125,415	16.30	17	49	TOTAL (lines 35 - 48)	
18 Housekeepers	18,241	20,653	199,894	9.68	18			
19 Laundry	5,656	6,892	66,120	9.59	19			
20 Administrator	1,840	1,856	73,237	39.46	20			
21 Assistant Administrator					21	C. C	CONTRACT NURSES	
22 Other Administrative					22			
23 Office Manager					23			Νι
24 Clerical	11,522	12,584	146,679	11.66	24			o
25 Vocational Instruction					25			Pa
26 Academic Instruction					26			Ac
27 Medical Director					27	50	Registered Nurses	
28 Qualified MR Prof. (QMRP)					28	51	Licensed Practical Nurses	
29 Resident Services Coordinator					29	52	Certified Nurse Assistants/Aides	
30 Habilitation Aides (DD Homes)					30			
31 Medical Records					31	53	TOTAL (lines 50 - 52)	
32 Other Health Care(specify)					32			ı
33 Other(specify) See Supplemental	3,815	3,815	39,660	10.40	33			
34 TOTAL (lines 1 - 33)	258,890	295,341	\$ 3,903,480 *	\$ 13.22	34	SEE ACC	COUNTANTS' COMPILATION REP	ORT

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	227	\$ 8,627	01-03	35
36	Medical Director	Monthly	9,500	09-03	36
37	Medical Records Consultant	Monthly	2,000	10-03	37
38	Nurse Consultant	Flat Fee	1,470	10-03	38
39	Pharmacist Consultant	Monthly	4,428	10-03	39
40	Physical Therapy Consultant	74	3,433	10a-03	40
41	Occupational Therapy Consultant	23	1,082	10a-03	41
42	Respiratory Therapy Consultant	5	374	10a-03	42
43	Speech Therapy Consultant	4	188	10a-03	43
44	Activity Consultant	34	1,863	11-03	44
45	Social Service Consultant	34	1,863	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	401	\$ 34,828		49

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11/30/05

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

^{*} This total must agree with page 4, column 1, line 45.

^{**} See instructions.

		5	Page	e 21		
Facility Name & ID Number	Knox County Nursing Home	# 0010561	Report Period Beginning:	12/01/04	Ending:	11/30/05
XIX SUPPORT SCHEDULES						

XIX. SUPPORT SCHEDULES											
A. Administrative Salaries		Ownership)		D. Employee Benefits and Pay				F. Dues, Fees, Subscriptions and Promotion	ıs	
Name	Function	%		Amount	Descript			Amount	Description	A	Amount
Marianne Wiesen	Administrator	0	\$_	73,237	Workers' Compensation Insur		\$_	172,054	IDPH License Fee	\$	1,990
					Unemployment Compensation	1 Insurance	_	87,265	Advertising: Employee Recruitment		2,600
					FICA Taxes			295,582	Health Care Worker Background Check		
					Employee Health Insurance	_	_	367,083	(Indicate # of checks performed)		
					Employee Meals				Med Forms/Publications		2,574
					Illinois Municipal Retirement	Fund (IMRF)*		282,159	Dues and Subscriptions		7,316
					Employee Incentives		_	5,379			
TOTAL (agree to Schedule V, li	ine 17, col. 1)		_				_				
(List each licensed administrato			\$	73,237			-				
B. Administrative - Other				· · · · · · · · · · · · · · · · · · ·			_				
							_	-	Less: Public Relations Expense		
Description				Amount			_	-	Non-allowable advertising		
M. Cecelia Landon - Interim Ad	lministrator		\$	4,800			-		Yellow page advertising		
		_	Ψ-	1,000			-		Tenon page autorising		
			_		TOTAL (agree to Schedule V	,	\$	1,209,522	TOTAL (agree to Sch. V,	\$	14,480
			_		line 22, col.8)	,	Ψ=	1,200,022	line 20, col. 8)	—	11,100
TOTAL (agree to Schedule V, li	ine 17. col. 3)		<u>\$</u>	4,800	E. Schedule of Non-Cash Com	nensation Paid			G. Schedule of Travel and Seminar**		
(Attach a copy of any managem		6)	*=	1,000	to Owners or Employees				or generally of 174 vor and sommer		
C. Professional Services	ent sei vice agreemen	.)			to Owners or Employees				Description		Amount
Vendor/Payee	Type			Amount	Description	Line#		Amount	Description	Д	Milouit
FR&R	Accounting		ф	6,586	Description	Line #	Ф	Amount	Out-of-State Travel	¢	
American Express	Accounting		Φ_	12,387			Φ_		Out-of-State Travel	⊅	
•			_				-				
Blucker, Kneer	Accounting		_	7,000			-		L. CA-A. TI		
Miller, Tracy, Braun	Legal		_	70			_		In-State Travel		
States Attorney Appelate	Legal		_	225			_				
	_		_				_				
	_		_				_				
			_				_		Seminar Expense		8,189
			_	_			_				
			_				_				
			_						Entertainment Expense		
TOTAL (agree to Schedule V, li	ine 19, column 3)				TOTAL		\$_		(agree to Sch. V,		
(If total legal fees exceed \$2500	attach copy of invoice	es.)	\$	26,268			-		TOTAL line 24, col. 8)	\$	8.189

* Attach copy of IMRF notifications SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year						Amount of	Expense Amor	rtized Per Year	•		
	Improvement Type	Improvement Was Made	Total Cost	Useful Life	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

			OF ILLINOIS				Page 23
	y Name & ID Number Knox County Nursing Home	#	0010561	Report Period Beginning:	12/01/04	Ending:	11/30/05
	ENERAL INFORMATION:	(12)	II			1. 1.211. 14.	
(1)	Are nursing employees (RN,LPN,NA) represented by a union? Yes	(13)		supplies and services which are of the		be billed to	
(2)	Are there any dues to nursing home associations included on the cost report? Yes			a addition to the daily rate, been propertion of Schedule V?	riy classified		
	If YES, give association name and amount. County NH Assoc \$1,600, IHCA \$2,815				_		
	<u> </u>	(14)		building used for any function other t	han long term	care services	for
(3)	Did the nursing home make political contributions or payments to a political			listed on page 2, Section B? No		For exampl	
	action organization? No If YES, have these costs		is a portion of the	building used for rental, a pharmacy,	day care, etc.)	If YES, attac	ch
	been properly adjusted out of the cost report? N/A		a schedule which	explains how all related costs were all	located to thes	e functions.	
(4)	Does the bed capacity of the building differ from the number of beds licensed at the	(15)	Indicate the cost o	f employee meals that has been reclas			
	end of the fiscal year? No If YES, what is the capacity? N/A		on Schedule V.		meal income l		ainst
			related costs?	No Indicate	the amount.	\$ N /A	
(5)	Have you properly capitalized all major repairs and equipment purchases? Yes						
	What was the average life used for new equipment added during this period? 10 Years	(16)	Travel and Transp				
				included for out-of-state travel?	No		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense			complete explanation.			
	and the location of this expense on Sch. V. \$ 42,864 Line 10		b. Do you have a s	separate contract with the Department			
			residents? N	, r	amount of inco	ome earned fro	om such a
(7)	Have all costs reported on this form been determined using accounting procedures			this reporting period. \$			
	consistent with prior reports? Yes If NO, attach a complete explanation.			all travel expense relates to transport	ation of nurse	s and patients	? 100% Ln 14
			d. Have vehicle us	age logs been maintained? No	_		
(8)	Are you presently operating under a sale and leaseback arrangement? No			stored at the nursing home during the	night and all	other	
	If YES, give effective date of lease. N/A		times when not				
				commuting or other personal use of a	utos been adju	ısted	
(9)	Are you presently operating under a sublease agreement? YES X NC)	out of the cost r				
(40)				ity transport residents to and fr			N/A
(10)	Was this home previously operated by a related party (as is defined in the instructions for			mount of income earned from p			
	Schedule VII)? YES NO X If YES, please indicate name of the facility	y,	transportatio	n during this reporting period.	3	\$ <u>N/A</u>	_
	IDPH license number of this related party and the date the present owners took over.	(17)	II	performed by an independent certifie	d	ti	Vaa
		(17)	Firm Name:	performed by an independent certifie	a public accou		tions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department			that a copy of this audit be included	with the cost r		
(11)	during this cost report period. \$ 111,690		been attached?		Not Comple		is copy
	This amount is to be recorded on line 42 of Schedule V.		been attached?	ii iio, piease expiaiii.	Not Comple		
	This amount is to be recorded on thie 42 of Schedule V.	(18)	Have all costs whi	ch do not relate to the provision of lo	na tarm cara k	seen adjusted	out
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V	(10)	out of Schedule V	? Yes	ng term care o	cen adjusted (Jul
(12)	for an individual employee? No If YES, attach an explanation of the allocation.		out of Schedule v	103			
	if i i i i i i i i i i i i i i i i i i	(10)	If total legal fees o	are in excess of \$2500, have legal invo	nices and a sur	mmary of cers	ices
	SEE ACCOUNTANTS' COMPILATION REPORT	(1)		tached to this cost report?	nees and a sur	illinary or serv	ices
	SEE ACCOUNTAIND COM ILATION REPORT			d a summary of services for all archi	tect and apprai	isal fees	
			1 Ituati in voices ai	is a seminary or services for all alcill	er and apprai	1000.	